# SCHOOL ADMINISTRATIVE DISTRICT NO.59

Monica Beach, BSN, RN School Nurse
Heather Sadler, BSN, RN School Nurse
Madison School District
Telephone : (207) 696-4607
Fax: (207) 696-5639

## HEALTH INFORMATION

Child's Name: Parent/Guardian Name:

Birth Date: Address:

Home Phone: Physician's Name:

Contact #1 (cell, work, etc):_____ Contact #2: _____

**MAJOR MEDICAL CONDITION(S):** (ie. Asthma,, diabetes, epilepsy, cystic fibrosis, cancer, heart disease, migraines, eczema, ADD, ADHD)

**Allergies:**

**MEDICATIONS:**

**CHILDHOOD ILLNESSES: (Please check if applicable and given month and year of illness)**

__Chicken Pox _____Chronic Ear Infections
(If 4 or more ear infections in 2-3 years. Or if has one currently.)

__German Measles

__Measles__ Seizures

__Mumps __ Meningitis

__Whooping Cough __ Tuberculosis

__Scarlet Fever

**HOSPITALIZATION(S):** (ie. Polytubes, burns, surgeries, etc.)

**AGEWhereReasonDoctor**

**ACCIDENTS:** (ie. Head bumps, fractures, etc.)

**AGEWhat HappenedCare Needed**

**PLEASE CHECK THOSE THAT APPLY**

**PRESENT DIFFICULTIES: BEHAVIORS:** Sleeping Problems_____ Thumb Sucking _____ Bowel Problems _____ Overactive_____ Bed Wetting_____ Eye Blinking_____ Appetite/eating Problems _____ Short Attention _____

Dental Cavities ____ Mood Swings _____ Last date of visit to dentist _____

Head Rocking_____

Hearing_____

Banging_____

Vision_____ Glasses _____

Nail Biting_____

Accident Prone/

**NUTRITION:** Clumsy_____ Food Allergies _____ Hurts Self on Purpose _____

_____ Unexplained Tantrums _____ Hits Others _____

Fearful _____

Shy_____

Has your child been through any upsetting experience that we should know about in order to better help your child as he/she begins school? (examples: divorce, abuse, death in family/ even pet, etc.)

_____

_____

**FAMILY HISTORY: (back to child's grandparents) PREGNANCY/BIRTH**

Migraines _____ Allergies _____ Normal _____ Problem(s) _____ Diabetes _____ Heart Disease _____
Epilepsy _____ Blood Disease _____ Birth Weight _____lbs. _____oz. Retardation _____Alcoholism _____
Cancer _____ Emotional Stress _____
Asthma _____ Strokes _____
Lung Disease _____ **VISION SCREENING: _____** Muscle/Bone Disease _____
Hypertension (high blood pressure) _____ **HEARING SCREENING: _____ Parent/Guardian Signature:**
_____Date: _____